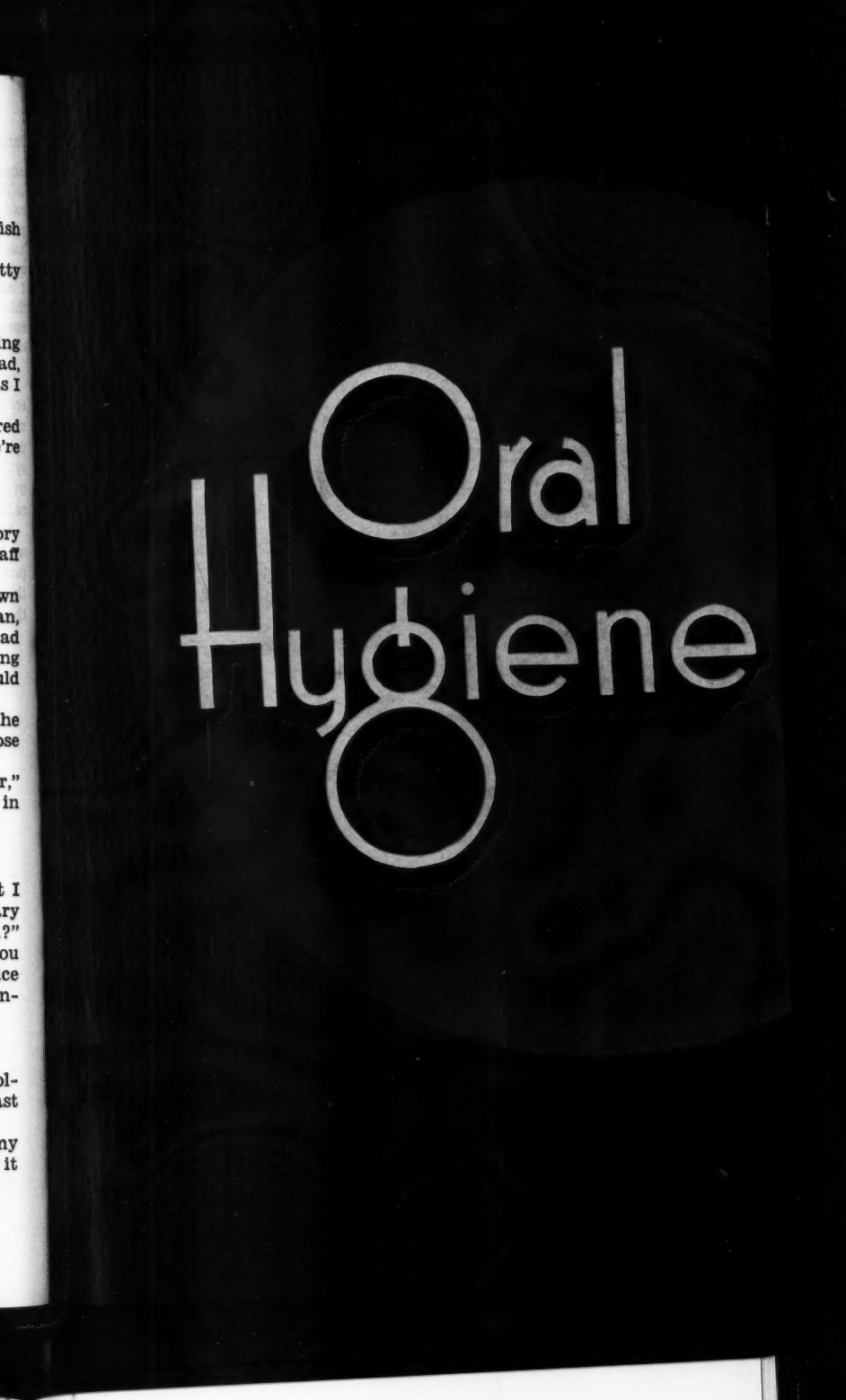
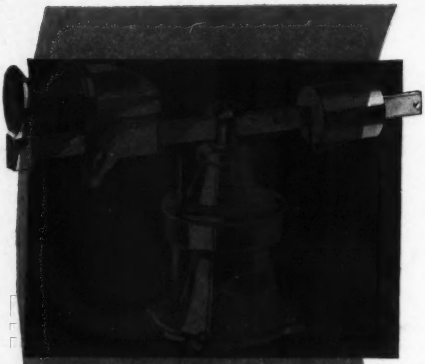

Oral
Hygiene



Wind the spring

Melt the gold

Let Go!

PERFECTION

It is as simple as ABC to cast with the Perfection Casting Machine. The spring which supplies the casting force is wound by giving the arm a few turns; the gold is melted in the separate crucible of the machine; the moment the gold becomes fluid, the arm is released by dropping the stop pin and the metal is thrown into the mold.

Regardless of the technic that is used for the production of an inlay or other cast restoration, when the casting stage is reached the Perfection Casting Machine will do all that a casting machine can do to insure a good result.

Perfection Casting Machine with accessories for small castings $25.00.

With Akers' flasks and counterweight for dentures and large castings $28.50.

THE *Cleveland* DENTAL
MANUFACTURING CO.
CLEVELAND, OHIO U.S.A.

VOL. 27, NO. 2

ORAL HYGIENE

FEBRUARY
1937

EDITORIAL OFFICE: 708 Church Street, Evanston, Ill.; PUBLICATION OFFICE: 1005 Liberty Avenue, Pittsburgh, Pa.; Merwin B. Massol, Publisher; J. J. Downes, W. Earle Craig, D.D.S., Associates; R. C. Ketterer, Publication Manager. CHICAGO: Peoples Gas Building. NEW YORK: 18 East 48th Street; Stuart M. Stanley, Vice-President and Eastern Manager. ST. LOUIS: Syndicate Trust Building; A. D. McKinney, Southern Manager. SAN FRANCISCO: 155 Montgomery Street, LOS ANGELES: 318 West 9th Street; Don Harway, Pacific Coast Manager. Member Controlled Circulation Audit, Inc.

HEALTH INSURANCE: *What Organized Labor Says About It*

by PETER T. SWANISH, Ph.D.*

ORGANIZED LABOR wields an important influence in the law-making assemblies of the separate states as well as in the Congress of the United States. This is a familiar fact to anyone who has observed its spokesmen at work taking the lead in initiating and mobilizing support for labor measures in our state legislatures and in Congress. No professional group can afford to dismiss the force of numbers of so outstanding an institution as the American Federation of Labor alone to say nothing of the latter's other sources of authority.[1] No professional body can escape the impact of that skill and intelligence, which was born out of a half-century of experience and hard work in the legislative halls of this country, and which has been for sometime, and is today, the peculiar possession of those who speak for organized labor.

Some years ago, an editorial in a metropolitan daily called attention to the qualities of this skill and then went on to say that "the American laborites don't have to send men to Congress as their British brethren do to the House of Commons. From the galleries they watch the proceedings. They are mighty in the committee rooms. They reason with the recalcitrant. . . . There are no abler or more potent politicians than the labor leaders out of Congress . . . "[2] Despite the almost general recognition of organized labor's authority wherever welfare legislation comes up for consideration, the dental and medical professions seldom, if ever, bother to inquire as to

*Chief, Division of Statistics and Research, Illinois Department of Labor.

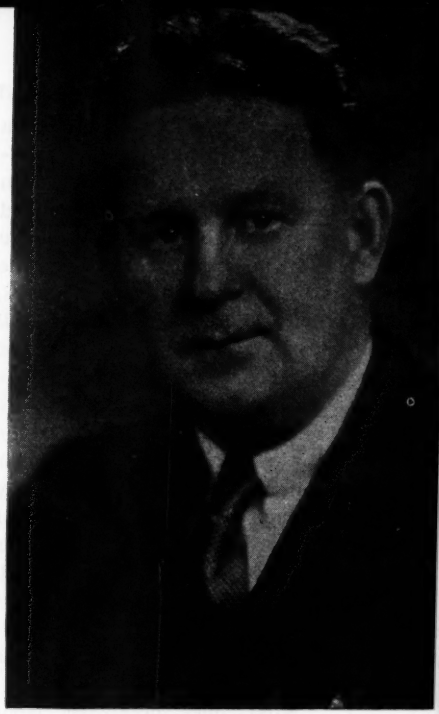
[1]The membership of the American Federation of Labor in 1936 was 3,422,398. As of December, 1936, the Federation was composed of 111 national and international unions; 914 local trade and federal trade unions; 49 state federations 734 city central bodies and 4 departments. The national and international unions had 32,906 subordinate local unions under their jurisdictions.

[2]Annals of the Am. Acad. of Pol. and Soc. Sci., page 16 (May) 1935.

what organized labor thinks about health insurance.

The non-partisan political policy of the American Federation of Labor, in one of its basic principles, calls upon its membership to support principles and ignore party labels; to go to the polls on election day and vote for candidates who can be trusted to support such measures as are vital to the well-being of working men and women and to vote against those who have opposed or might oppose labor measures. "Stand faithfully by our friends and elect them. Oppose our enemies and defeat them"—this is organized labor's battle-cry on election day.

This policy negates the ambitions of the political boss who cherishes "regularity" above everything else and bawls "stand by your party, right or wrong; be regular even though the government falls." It also gives organized labor an upper hand in determining the form and content of many legal institutions which go to make up our democracy. By rewarding loyalty to labor's cause, it serves to elect men to office who will support and work to give practical effect to its demands. By punishing its "enemies," it works to keep men out of office who would place the interests of other groups above those of labor.



PETER T. SWANISH

What organized labor thought about health insurance was dismissed as of no consequence by members of the medical profession who argued the matter in print. This has already been pointed out. One may, therefore, properly raise the question: "Why worry about the matter now? Since the die is cast, why not sit back and see what happens next?" There would be some sense to an attitude such as this were it not for the fact that there still remains to be settled the matter of detail—

the form and the content of a system of health insurance, especially in so far as state action on health insurance is concerned —matters of vital importance and of especial concern to the dental and medical professions. As to whether this country shall or shall not have a system of health insurance, it is my conviction that notwithstanding the sentiment of any group outside the ranks of organized labor concerning the wisdom or folly of such a system, the position of organized labor on the matter and what it does about its stand, combined with the tremendous weight of its influence in lawmaking will ultimately settle this issue for professional groups.

What does organized labor think about health insurance? Has it taken its stand?

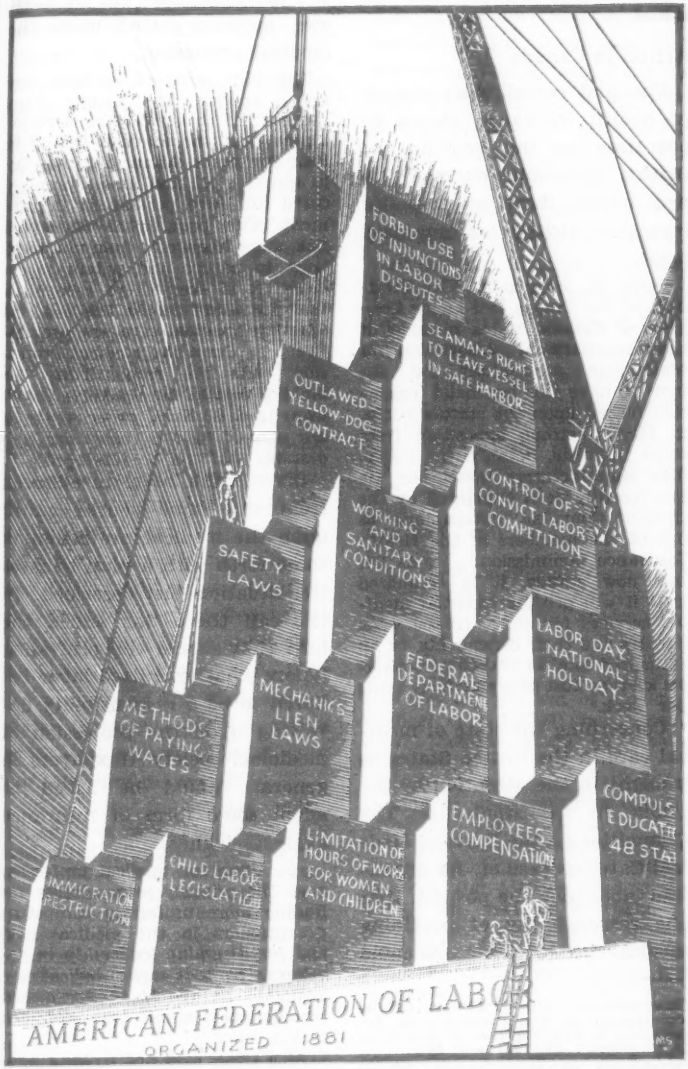
To begin with, Convention No. 24, adopted by the International Labor Organization (the society set up by the Versailles treaty numbering representatives from forty-eight nations) in 1927, and which was to become effective July 15, 1928, obligated member governments to set up systems of compulsory sickness insurance for workers and commercial undertakings; for those in the liberal professions; and for outworkers and domestic servants. Convention No. 25, adopted at the same time, called for a system of compulsory sickness insurance for agricultural workers and in both conventions minimum standards were prescribed.

Conventions adopted by the Special Maritime Session of the International Labor Conference (annual congress of the official delegations from member nations) only last October included the sickness insurance treaty which provided for the establishment of a system of sickness insurance for seamen similar to systems existing in most countries for workers ashore. This convention was adopted by a vote of sixty to five.[3]

On January 15, 1936, the Executive Council of the Trades and Labor Congress of Canada, and an associate delegation of Canadian representatives of affiliated and international unions presented their suggestions for a legislative program to Prime Minister W. L. Mackenzie King. Among other measures included in the list of suggestions was Social Insurance.

On social insurance it may be pointed out that modern industrial conditions are such that the individual worker finds he is wholly unable to provide any measure of security for himself and dependents against the hazards of unemployment, ill health and old age. In consequence, he must look increas-

[3]American Federation of Labor Weekly News Service, page 2 (November 21) 1936.



Protective legislation favorable to labor enacted in the United States during the last seventy-five years.

ingly to the employer and the state.[4]

Action in Canada

The first contributory system of health insurance placed in operation in the Province of British Columbia during 1936 was hailed there as a major legislative victory for organized labor.

Percy R. Bengough, Vice-President of the Trades and Labor Congress of Canada and a member of the International Association of Machinists, successfully led the fight to have this beneficial legislation placed upon the statute books, in face of strong opposition from other interests, notably, the Canadian Manufacturers Association. He has recently been appointed by the British Columbia government as one of the members of the Health Insurance Commission. . . . As the law now stands, it is estimated that it will provide essential medical services for about 110,000 wage earners and their dependents, or an estimated total of 275,000 persons at an average cost of about forty cents per week.[5]

Concerning the state of medical care in the United States as brought to the attention of the public in the studies of The Committee on the Costs of Medical Care, spokesmen for organized labor took the position that the responsibility of providing medical care for those who could not meet its cost out of their own incomes rested upon the medical profession.

The high costs of medical care are a spectre that haunts many homes. The costs of a single major illness puts the average family in debt for years. Minor illnesses lay in wait for all and unless properly cared for leave permanent impairment. The poor, even when too sick, more frequently than not, must trust to nature and patent medicines. It is everywhere recognized that for most people the costs of adequate medical care are prohibitive. . . . *Upon the medical profession rests the responsibility for making medical care possible for all who need it. Such experiments as are covered by this report are suggestions that can be developed.*[6]

Six months later, an editorial from the same source called upon the medical profession to come forth with a plan to meet the situation just described. To the call there was added the hint that should the profession ignore what organized labor believed to be a responsibility devolving upon the profession of medicine, society (taxpayers in general) would be asked to adopt some form of insurance against sickness.

. . . Upon the medical profession rests the primary responsibility for finding more uniformly competent practitioners in the medical field and *for assuming leadership in developing plans to make medical care available to all. If the organized medical profession does not act, society must.*[7]

At a time, and not so long ago,

[4]International Fire Fighter, Official Publication of the International Association of Fire Fighters, Washington, D. C., pages 3, 15 (February) 1935.

[5]Machinists Monthly Journal, Official Organ of the International Association of Machinists, Washington, D. C., page 843 (September) 1936.

[6]Editorial, American Federationist 39: 1223 (November) 1932.

when the profession might have "written its own ticket" on the subject of health insurance, leadership in medical circles denounced the scheme as incompatible with the established traditions of medical practice. Whatever else may be said for or against the quality of professional leadership, it offered no plan. This failure to bring forth a workable system invited spokesmen for organized labor to make the next move. In taking the next step, organized labor turned its demands for security against "the haunting spectre of the high costs of medical care" to the State, certain that such a request would not fall on deaf ears.

In a resolution brought before the Fifty-Fifth Annual Convention of the American Federation of Labor, held in Atlantic City, New Jersey, October 7-9, 1935, the position of the wage-earner under the existing organization of medical care was described in the following manner:

Workers in the United States during times of illness are not only confronted with loss of wages, but are forced to pay exorbitant medical and hospital bills which frequently force them into debt and poverty . . . although health insurance has been in successful operation in all industrial nations for more than a generation, it is ignored in the Social Security Act passed by the first session of the Seventy-Fourth Congress.[8]

In the action taken upon this resolution the American Federation of Labor "urged the enactment of socially constructed insurance through Congress and the individual states."[9]

The Fifty-Sixth Annual Convention met in Tampa, Florida, November 16, 1936. At this convention, the Executive Council of the American Federation of Labor reviewed the action taken on health insurance at previous meetings. It declared that:

In accord with resolutions adopted by the past two conventions, we have reviewed the available information on the costs of medical care, and methods of pooling the costs of medical care by cooperative and health insurance legislation.

We find additional reasons for recommending health insurance and provisions for medical service within the reach of all in the relation between sickness and dependency. If we as a nation had considered and met the problem of providing medical care for all, our present relief problem would be greatly simplified.

Medical care is not provided according to need, but according to capacity to pay . . . A barrier, in a large part economic, stands between the practitioners, able and willing to serve, and patients needing the service but unwilling or unable to pay for it. Unfortunately, disease visits the poor with even greater frequency than those able to pay the doctors.

[7]Editorial, American Federationist 40:345 (April) 1933. American Federation of Labor Weekly News Service (December 16) 1933.

[8]American Federation of Labor Convention Proceedings Summarized, American Federation of Labor Weekly News Service (November 16) 1935.

[9]Footnote 8. ibid.

REPRODUCED BY PERMISSION FROM NEW YORK HERALD-TRIBUNE, NOVEMBER 23, 1936, FOR PUBLIC RELATIONS BUREAU, MEDICAL SOCIETY OF THE STATE OF NEW YORK, 2 EAST 103D STREET, NEW YORK CITY.

Health Insurance Study Is Initiated By Security Board

Experts Directed to Learn Cost of Medical Service and Cash for Time Lost Off Job Through Illness

Taxes Seen as Only Financing Method

Roosevelt Promise of No New Levies May Force Delay of Plan for Year, Even if It Is Approved

By Albert L. Warner

WASHINGTON Nov 22.—The Social Security Board has initiated a study looking to possible proposal of a major addition to the social security system in the shape of health insurance, it was disclosed today.

As large a Federal project for social welfare as either unemployment insurance or the old-age benefit insurance system, health insurance would provide both medical services and cash payments in partial compensation of wage losses due to illness. Should legislation for this purpose be sponsored, it would probably be of the same universal type as the old-age benefits. The coverage would extend to most of the working population of the nation and taxes would be required to finance it.

Early Proposal Delayed

An official proposal considered two years ago, but postponed, contemplated establishment by the Federal government of minimum standards for health insurance practice and pre-

the employer, and the old age benefits will cost 6 per cent, shared equally by employers and employees. State and Federal money, however, is already being raised and spent for a certain amount of medical care which would be covered in the service offered by health insurance. It is held improbable that any recommendation would contemplate raising all the cost of health insurance from pay roll taxes.

The Security Board's study will be under the general direction of Walton Hale Hamilton, economist head of the research division and former member of the National Industrial Recovery Board. The authorization in Section 702 directs the board to study and recommend "the most effective methods of providing economic security through social insurance and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation and related

NEW YORK
Herald Tribune

Tuesday, December 1, 1936

Nationalized Medicine

The Social Security Board let it be known in Washington a few days ago that it had authorized a study of health insurance on a nation-wide scale as a corollary to unemployment insurance. The board has made no commitment in favor of a Federal system of health insurance and has yet to consider what form such legislation might take.

The letter which appeared on this page recently from Dr Floyd S. Winslow, president of the New York State Medical Society, opposing warmly such a system heralds a storm of criticism which will burst upon Washington if legislative support of such a program is ever sought. For, with rare exceptions, every medical association or society, national, state or county, in the United States, continues to be uncompromisingly hostile to "socialized medicine."

Yet certain conditions exist in this country which argue for a much wider distribution of medical services than now exists. In some quarters they seem to argue for heavier subsidies from public funds for public health work. Most of these conditions and needs are, we believe, recognized by organized medicine. In rough outline they are as follows: There is a big element in the population either needy, ignorant and reckless of health or with low earning power but a real pride that gets much less medical attention than it should. Aside from all humanitarian considerations, this is a matter for grave public concern. Those persons disabled by neglected injuries or illnesses are likely to become permanent and expensive burdens on private charity or public funds. They also incubate sickness to the detriment of the public health. Next, there are more well trained and competent doctors and nurses in the United States than can earn a fair return on their investments in education and training. This makes the cost of medical attention to those of average income, who want medical care and want to pay for it, discouragingly high.

Faced with these conditions, all those persons who would rather have the government take any difficult problem off their minds and solve it expensively and inefficiently than think and work it out for themselves clamor at once for compulsory health insurance under Federal control. Accepting such propaganda as a challenge, the medical organizations become so bitterly (if justly) critical of every compulsory insurance scheme—and are so much on the defensive—that they appear in their publications to be taking a let-well-enough-alone attitude. Against "socialized medicine" in every form that has been tried abroad, they argue from abundant data that it constitutes an enormous tax burden, that it lowers the quality of medical care for all, that it does not improve public health and that it forfeits through perfunctory, impersonal treatment the confidence of those very elements in the population which it is designed to benefit.

These objections, when examined in detail, are enough to line up the average conservative American layman behind the medical profession in its hostility to compulsory insurance. But mere hostility is not enough. The gap in medical care must be studied and a sound remedy devised. Otherwise the "socialiser," who has the bit in his teeth, will prevail. To save the medical profession and the nation from the affliction of another European institution, about as well suited to our temper as peace-time conscription, it seems to us that the doctors will have to consider forthwith how medical, nursing and hospital service can be rapidly extended in conformity with the public interest and with their professional ideals.

. . . The problems of providing medical care for the prevention and care of diseases are fundamental to the conservation of our nation. *These are not problems that can be safely left to individual initiative, for life itself is at stake.*

. . . This inspires the question how adequate medical care can be supplied to all. *That can be done only by the federal government.*

. . . On the basis of facts presented we recommend that the Convention of the American Federation of Labor *urge the federal government to create a commission to*

study and recommend plans for coordination and improvement of our provisions for social security and their expansion to include compensation and medical care for sickness.[10]

The initiation of a study along the lines recommended in this resolution was announced while the Convention was still in session. According to press accounts, the Social Security Board is said to have a study under way "looking toward the proposal of a major addition to the social security system in the shape of health insurance. As large a federal project for social welfare as either unemployment insurance or old age benefit insurance, health insurance would provide both medical services and cash payments in partial compensation of wage losses due to illness."[11]

While the official publications of the unions affiliated with the American Federation of Labor do not, as a rule, exhibit the same degree of persistency as the latter, they are, now and then, more emphatic in their insistence upon the enactment of measures providing health insurance. In *Advance*, the reviewer of I. S. Falk's[12] "Security Against Sickness: A Study of Health Insurance: America's Next Problem in Social Security," concludes his estimate of this work in a most vigorous fashion:

> Who is going to put compulsory health insurance through Congress —if necessary over the dead bodies of the medical politicians who stalled and bluffed the President until it was kept out of the Social Security Act? Who is going to organize public support in back of honest technicians like Falk and forthright advocates like Kingsbury who have defined the problems and charted their solutions—and who, incidentally, have paid stiff prices for their courage and honesty? It looks like one of labor's next jobs. It will be a big one: the medical-politicos are tough, one readily grants. But they have never had the mighty force of labor's opinion to contend with. True, the medical boycotters took Milbank and the Borden Company the way Grant took Richmond. But labor may be something else again.[13]

Simply because less space is usually given to the subject of health insurance in the many publications of the trade unions affiliated with the American Federation of Labor, it does not follow that the spokesmen for the membership are less interested or less determined to have health insurance made a part of the Social Security program. Such journals devote more thought and space to the particular problems of their trade and to the activities of their

[10]American Federationist 43:1258, 1261, 1263; Editorial, 43:134 (February) 1936.
[11]Chicago Journal of Commerce (November, 23) 1936.

[12]An analysis of the book Security Against Sickness: A Study of Health Insurance: America's Next Problem in Social Security by I. S. Falk will be published in March, 1937, ORAL HYGIENE.
[13]Advance, published by the Amalgamated Clothing Workers of America, New York, page 24 (August) 1936.

locals. Because of limitations of space, the discussion of health insurance in trade union publications runs in terms of its main features for the most part. Their editors are closer to the needs and problems of their trades than they are to the broader implications of an argument for health insurance. For instance, the Doctor H. H. Horner statement made before the New York State Dental Society, which was quoted to the effect "that not more than twenty-five per cent of the people in the United States get regular dental care," was interpreted as a "convincing argument for steady employment and higher wages,"[14] in several trade union journals.

The American Federation of Labor points the way. Its voice is the voice of authority in matters concerning labor's well-being. Its policies are the policies of the affiliated membership for the most part. It has taken its stand. How soon the enactment of health insurance measures into law will be hailed as a major legislative victory for organized labor in this country, as it was in Canada this year, is an open and pertinent question.

[14]The Butcher Workman, (June 1) 1936; Commercial Telegraphers' Journal, page 75 (July) 1936; Journeymen Plumbers' and Steam Fitters' Journal, page 26 (June) 1936.

6751 *Newgard Avenue*
Chicago, Illinois

ANNUAL INDEX AVAILABLE

The annual index covering the 1936 volume of ORAL HYGIENE will be ready shortly. You can obtain a copy gratis by writing to the Publication Office, ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh, Pennsylvania.

THE DENTAL ASSISTANT
in the Rôle of Receptionist

by H. A. NELSON, D.D.S.

AT THE OUTSET, let me say that I freely admit that the dental assistant is an indispensable asset to the dental profession. Without her help it would be impossible to maintain a high standard of efficiency in the dental office. Nevertheless, my observations of assistants in action have not always been flattering. Among the dental assistants I have met over a period of several years there have been obvious deficiencies in some of them with respect to attitude, appearance, and manner, which I believe should be mentioned. I am speaking now of the dental assistant in her capacity of receptionist.

Number one: the would-be movie star (the escapist type).

It seems to me that the dental assistants I know fall naturally into four groups: the would-be movie star or escapist type; the sluggish type; the carelessly dressed type; and the competent dental assistant. Fortunately, by far the largest number of dental assistants come under this last category.

The Escapist Type

The would-be movie star or escapist type is really an amusing and interesting specimen. What she lacks in knowledge is counteracted by a none too subtle sex

appeal. Like the unhappy fish, she is decidedly out of her sphere and she knows it. Consequently, the escapist attitude. She is trying to escape from her humdrum job and from herself. She knows it would be unwise for her to give up her present position until she finds another and, work being hard to find, she lingers on. She discovers it is impossible to run away from her job, so she turns to herself and says defiantly, "At least I don't have to be as dull and monotonous as my work. I'll be scintillating, amusing, and as attractive as a movie star." She mascaras her eyelashes until the ends of them are heavy with black beads and rouges her lips until she looks like a caricature.

Number two: the sluggish type (who somehow manages to get through the day).

She meets all persons at the door with a condescending attitude and then by degrees she melts and is quite friendly. Luckily for her she has learned one thing and that is to keep her teeth clean, and so when she smiles she displays a row of gleaming teeth. She is as nonprofessional as an amateur athlete. If the patient happens to mention her dental difficulties, she listens with an inattentive ear. This young woman isn't dumb—she just isn't interested; it's all so boring. She has an irritating way of making you feel that you have intruded on her privacy or interrupted a conversation she was having over the telephone. As I said, she does in time become friendly, but it is a friendliness composed more of detachment and tolerance than of genuine warmth. And when one leaves the office one wonders how this girl manages to put up with the tediousness of greeting the women patients.

Then suddenly you realize that you have formed a definite, unflattering opinion of the dentist because of his assistant. She has mirrored not only the quali-

fications of the dentist but of the professional status of his office as well, all because it is of more importance to her to escape from her drab self than to be a good assistant. As a receptionist, she has failed miserably.

The Sluggish Type

Number two: the sluggish type. The first girl that I tried to picture to you is, despite her faults, an amusing person; the second one, however, is more to be pitied than anything else. She is impervious to all external influences. She can no more absorb knowledge or finesse from her surroundings than a leopard can alter his spots to blend with the foliage about him. If she is clean and neatly dressed, it is usually from accident rather than because of an inherent desire to be so.

There is an art in being an efficient receptionist. I doubt if this sort of girl even knows the meaning of the word. She opens the door because someone has rung the bell. She says "Hello" because the ringer of the bell has said "Hello." She may have seen the patient a dozen times before, but it never occurs to her to call the woman by her name, welcome her in a friendly fashion, or to inquire about her health. Sometimes she will request the patient to be seated or merely indicate a chair, but usually such amenities never occur to her.

Apathetic and listless, she does somehow manage to get through the day. She is entirely myopic so far as her outlook on her future is concerned, her living being a day to day affair. For her, I have deep pity because, tragic as it is, she knows no better and probably never will.

The Careless Dresser

Number three: the carelessly dressed type. I honestly think it is better to designate this person as the Unforgivable Sin. She looms up larger in number than the first two types, and naturally is encountered more frequently. If I appear to exaggerate her propensities for deplorable grooming, it is because I feel that by accenting her failure I will be better able to call your attention to the lesser things that sometimes go unnoticed but which detract from a neatly and properly dressed dental assistant. The first glaring example of this type of person is the one who wears a hooverette. I came across an example of this type not so long ago. She wore black, high heeled pumps, a brown woollen dress with long, tight sleeves and a fussy neckline. Large amber beads hung peacefully upon her bosom, and her shell-pink ears were decorated with two amber earrings

that dangled whenever she moved her frowzily combed head. And over her dress she wore the hooverette. She didn't wear it for any hygienic purpose, only to protect her dress. Her two brown clad arms, one of which was encircled by a heavy amber bracelet, extended down from the short sleeves of the smock like two tree trunks. The button was missing on this strange white covering of hers, so she had it pinned with a charming brass safety pin. All in all, she resembled someone who had had a hard night, and now had arrived at the stage where she didn't care what happened next.

This sort of person may have the ability to meet everyone who comes into the office in a pleasant manner; she may be able to mix amalgams to perfection; and she may worry more about the figures in her dentist's books than about her own, but she is so slovenly in appearance that all her good assets become as nothing. She creates a vivid but bad impression.

As I said before, this is an extreme case, but I have seen otherwise neatly dressed assistants with untidy finger nails or with blood red ones. Certainly such under and over hand grooming is equally offensive to good taste.

To remark that a girl's complexion is one of her greatest attributes is to utter a trite aphorism. Trite or not, it is true. To attempt to conceal a cloudy or unhealthy complexion by a heavy coating of powder or rouge is only drawing attention to one's blemishes. A little care as to diet and a few facial treatments will help tremendously. I have discovered that those girls who are negligent about their complexions are equally careless about the trimness of their persons. They sometimes even for-

Number three: the carelessly dressed type (or the Unforgivable Sin.)

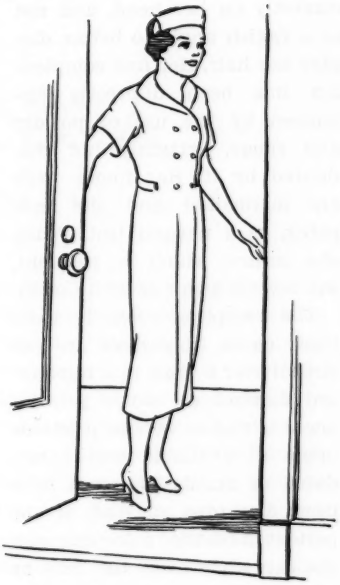
get that it isn't such a bad idea to practice a little oral hygiene upon themselves, if for no other reason than for appearance sake.

If I seem to be laying stress upon cleanliness and neatness, it is because I consider them to be as vital and as integral a part of a proficient receptionist as the manner in which she invites you into the office and endeavors to put you at your ease.

The Competent Assistant

Number four: the competent type of dental assistant. Fortunately, as I have said, this last group includes the majority of those I have met in dental offices. She meets everyone at the door with a ready smile, is courteous, confident of her ability, contented in her work, and perfectly at ease in her surroundings. If it is necessary for the patient to wait before being admitted to the dentist, she sees that he is made comfortable, says a few friendly words to him, and if it is someone who has made several previous visits she inquires about his health. Being an alert assistant, she can in a surprisingly short while determine the mood or the nervous state of the patient, and thus help the dentist to decide the best procedure to follow.

Her manner, while it is at all times friendly and cheerful, is



. . . And number four.

professional. She knows that it is not necessary to wear a frozen expression, be cold, or officious in order to be duly impressive. In other words, her natural good breeding comes to the front and she is just herself.

She is always dressed in white from her shoes to her cap. Under her starched, unwrinkled gown, she wears a slip not a street dress. The heels on her shoes aren't run over and the seams of her stockings run straight up the back, and never under any circumstances do they encircle her shapely leg like a clinging vine. Her cap is placed

correctly on her head, and not at a rakish angle to better display her hair. Her fine complexion has been discreetly enhanced by the use of powder and rouge, certainly not disfigured by it. Her finger nails are manicured and she uses polish in a natural tint. When she smiles, which is frequent, she reveals a row of white teeth.

The reception room is spotlessly clean. Magazines are not strewn over a table in a haphazard manner or, worse yet, allowed to rest in various positions upon all available seats. Outdated or mutilated issues have been discarded so that, if the patient must wait a few minutes, she can while away the time by perusing a magazine new and fresh as the moment itself. Here the assistant has shown herself to be a capable receptionist by having taken care of these little details that mirror in so large a fashion the abilities of the dentist and of herself.

When the patient leaves that office, he is confident that he has selected a competent dentist, a man of high professional ethics, and one who is actually interested in his health. He also knows that his dentist has an efficient assistant, one who is understanding, sympathetic, and eager to be of the utmost service to him. All this appreciation is due in no small measure to the dental assistant, for it was she who first set the professional tone of the office and gave to the patient that much needed confidence in the dentist. Therefore, as a receptionist, this young woman is entirely a success. She has fulfilled the obligations of her position, and she is indeed an asset to her employer.

40-40 *Forley Street*
Elmhurst, New York

EDITOR'S NOTE: Dental assistants who wish to comment on this article may send their letters to the Editor of ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

My Opinion of ORTHODONTIA

by NORMAN L. ROSS, D.D.S.

YEARS AGO in starting my orthodontic practice, a fundamental axiom that I clung to despite all discouragement was, "Orthodontia is easy." Today, having come a long way in this specialized field, with many bridges (orthodontic, not prosthetic bridges) behind me, my opinion still is, "Orthodontia is easy."

For years I have listened to various orthodontists on the lecture platform and in dental publications proclaim the intricacies and difficulties of their particular field and berate the general practitioner for presuming to venture within the sacred domains of their specialty. For years I have waited in vain for the general practitioner to reply to these unwarranted attacks and criticisms.

The general practitioner whose interest lies in that direction knows, and I know, that he can treat orthodontic cases successfully. He knows too that only his occasional failure has reached an orthodontist's hands, and that he has been judged by his failures rather than by his successes. If the general practitioner has been in practice for any length of time, he has seen failures on the part of orthodontists, but in an ethical manner he has judged the orthodontist by his successes and charitably overlooked his failures.

Not so these specialists! In all dentistry there is no specialized group so aloof and contemptuous of the general practitioner and so secretive about their special knowledge as the organized orthodontists. Why? Because orthodontia is easy!

Orthodontia being easy to the men who know their specialty, and being exceedingly costly to the individual patient, has of necessity been surrounded by mystifying and awe inspiring appurtenances. I have seen, in expensive orthodontists' establishments, a girl employed exclusively to spend hours on each plaster model, and another employed exclusively as a draughtsman enlarging and reproducing surveys of the plaster models on paper. I consider these items as luxurious and unnecessary extravagances, but they form a most impressive spectacle for the new patient, and

you may be sure these features are always brought to each new patient's attention. It somehow helps to explain and justify the $1,000 fee.

I remember early in my career visiting several celebrated orthodontists to discuss methods of learning the specialty. Invariably the obstacles and difficulties of the specialty were brought to my attention. But I was not impressed except with the idea that the secrecy, mysticism, patented appliances, and high fees of orthodontia approach closer to quackery and questionable ethical practices than do those of any other dental specialty.

Continuing my search, I found an orthodontist who took keen delight in the practice of his specialty and to whom orthodontia is easy. I studied under him and found the study and practice of orthodontia, as I had expected, fascinating and easy.

In my own practice, orthodontic fees are modest for the individual patient, and the success of the practice is based upon volume. Time of treatment has been reduced by careful diagnosis and the employment of effective mechanisms. Since I enjoy my work and find orthodontia easy, no worthy patient is ever refused because of inability to pay my standard fee. For me, there is pleasure and fascination in a volume of orthodontic work—and the work is easy!

Liberty Square
Port Chester, New York

EDITOR'S NOTE: This article represents the point of view of the author not of this publication. Readers are invited to comment on it or express their own opinions of orthodontia.

DENTAL MEETING DATES

University of Buffalo Dental Alumni Association, regular meeting, Hotel Statler, Buffalo, February 24-26.

Five State Dental Post Graduate Clinic, Wardman Park Hotel, Washington, D. C., March 7-10.

Alabama State Dental Association, sixty-eighth annual meeting, Battle House Hotel, Mobile, April 12-14.

American Society of Orthodontists, thirty-fifth annual meeting, Edgewater Beach Hotel, Chicago, April 19-22.

North Carolina Dental Society, sixty-third annual meeting, Carolina Hotel, Pinehurst, May 3-5.

Dental Society of the State of New York, sixty-ninth annual meeting, Waldorf-Astoria, New York City, May 4-7.

Pennsylvania State Dental Society, sixty-ninth annual meeting, William Penn Hotel, Pittsburgh, May 4-6.

Tennessee State Dental Association, seventieth annual meeting, Knoxville, May 10-13.

Sketch of a Dentist

IN MOTION

by S. J. LEVY, D.D.S.

ENTER THE BUSY dentist who is hoping for a pick up in business.

There was talk about the general revival of business in the industries. Dentists read the news with avidity and shrugged their shoulders.

"There is no pick up in my office," a colleague said to me.

"Isn't there?" I said.

"Well, I'm working, if that's what you mean."

"If you are working you should have no cause to complain."

"But, what," said my friend, "shall I do? I have plenty of patients but never seem to accomplish much."

The man opened fire. He had the facts on how a dentist could work like a horse and not get paid for it. I was not convinced.

"Ever keep a diary?" I asked.

"Not me."

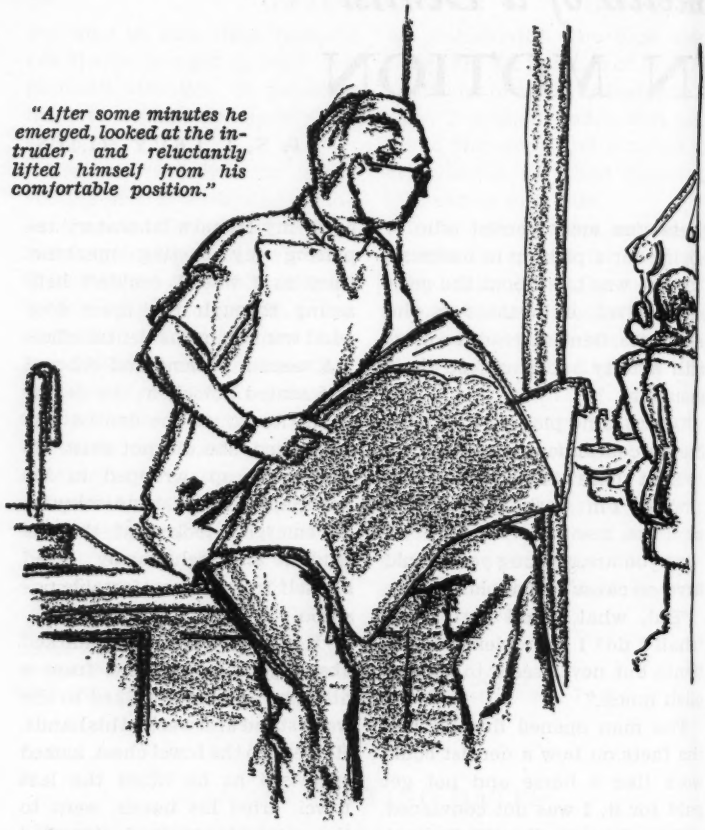
"Try it. Write down everything you do, account for every minute you are in the office. Don't be scared. You needn't show it to me or anybody else. Just read it before going to bed every night. That's all."

A few days later I happened to be in my friend's laboratory repairing my casting machine. Busy as I was, I couldn't help seeing through the open door what went on in the dental office.

A woman patient had entered and seated herself in the dental chair. As far as the dentist was concerned, she did not exist. He was chest up, wrapped in his newspaper. After some minutes he emerged, looked at the intruder, and reluctantly lifted himself from his comfortable position.

"How do you do?" he remarked absently to the patient from a distance and then walked to the wash stand and washed his hands. He went to the towel chest, looked surprised as he lifted the last towel, dried his hands, went to the patient, stopped, traveled back to the desk, telephoned to the towel man, walked back to the wash stand, washed his hands, looked for the discarded towel, found it, dried his hands, threw it into the waste basket, and walked to the chair.

"Open your mouth," he commanded. The patient wanted to



"After some minutes he emerged, looked at the intruder, and reluctantly lifted himself from his comfortable position."

say something but was checked. "Just a minute," he said, "I have to sterilize my instruments."

He gathered the instruments, threw them into the cold sterilizer, went back to the desk and began to search for the patient's record card, looked in the index box among the pile of letters, bills, statements, and advertisements on the desk, inside the desk, underneath the desk—it was nowhere to be found.

He was interrupted by a knock at the door. A patient wanted to know how much longer he was to wait. The dentist told him he'd be ready in a few minutes. The patient said he couldn't wait and wanted an appointment so he

wouldn't have to wait next time.

"Just a minute," soothed the dentist, "I'll get the appointment book. Who took my appointment book? Here it is! No, it's the telephone book. Never mind. I'll mark it down on a piece of paper."

After six minutes of futile attempts to make a time adjustment, the dentist asked the patient to telephone tomorrow morning when the appointment book would have been found. He stopped in the middle of the room, hesitated, went to the washstand, washed his hands, looked for the towel, pulled it out of the wastebasket, dried his hands, and walked over to the patient.

"Open your mouth, please." He looked in. "Oh, yes—your record card." Again the hectic searching began.

Unable to find the card, the dentist hurried back to the patient.

"Now, Miss, open your mouth. Oh, yes, your bridge." Searches the drawers again. The telephone rings. A lively and detailed conversation lasts for eight minutes. It stops when the dentist is attracted by the boiling sterilizer. He takes out the instruments, places them on a tray, washes his hands, takes the mirror and explorer into his hands.

"At last we can see what's what," he says to the waiting patient. His face is one big question mark. He brightens up with an idea. "When were you here last?" he asks the patient.

"That's what I was trying to tell you ever since I came in—I am here for the first time."

The patient had been sitting in the chair exactly forty-six minutes. I was through with my work in the laboratory. I thanked my friend and said good-bye. On the way out I passed a full reception room.

1230 *Sheridan Avenue*
New York, New York

STATE BOARD EXAMINATION

The State Board of Registration and Examination in Dentistry of New Jersey will hold its annual examinations, commencing Monday, June 28, and continuing for five days thereafter. Any person desiring to apply as a candidate must file the preliminary application, together with the examination fee of $25.00, on or before March 15. For information, wire Doctor Walter A. Wilson, Secretary, 148 West State Street, Trenton, New Jersey.

RATE YOURSELF ON DENTAL FACTS

How MUCH DO you know about ordinary dental facts? Behind your intellectual disguise, are there some blank spaces you hope your patients will never discover? Perhaps you often use terms in an impressive manner without actually knowing what they mean. Why not take your pencil and check up on yourself? Complete each of the ten statements listed here by marking with an X in the square following the one you think is true. The correct answers will be found on page 195. Give yourself a score of ten for every statement you have completed correctly.

1. Gutta percha is similar to:
   - a. cactus ☐
   - b. corn fodder ☐
   - c. caoutchouc ☐
   - d. igneous rock ☐

2. Molybdenum is:

   - a. an island in the South Seas ☐
   - b. part of an internal combustion engine ☐
   - c. another name for *Moby Dick* ☐
   - d. a metallic element ☐

3. Novocaine has the chemical formula of:
   - a. $C_{13}H_{20}O_2N_2HCl$ ☐
   - b. $C_{12}H_{22}O_{11}$ ☐
   - c. $CHCl_3$ ☐
   - d. $C_2H_2(OH)_2(COOH)_2$ ☐

4. Odontexesis is:

   - a. a kind of taxidermist ☐
   - b. the name of a dental operation ☐
   - c. a city in Greece ☐
   - d. a radio quartet ☐

5. Epistaxis is:

   a. a section of the Social Security Act ☐
   b. a form of sunstroke ☐
   c. the result of an injury to the nose ☐
   d. a monument in London ☐

6. William Harvey:

   a. named a comet ☐
   b. founded a chain of restaurants ☐
   c. described the circulation of the blood ☐
   d. played half-back for Yale in 1916 ☐

7. Marginal ridge is the name of:

   a. a battle field in the World War ☐
   b. part of a tooth ☐
   c. a moustache ☐
   d. a method of contour plowing ☐

8. The gold inlay was first described by:

   a. Thomas Taggart of Indiana ☐
   b. Perigord de Talleyrand of France ☐
   c. William Taggart of Illinois ☐
   d. Theodore Timken of Utah ☐

9. The theory of focal infection was advanced in 1910 by:

   a. William Hunter ☐
   b. Charles Evans Hughes ☐
   c. Leslie Howard ☐
   d. John Hunter ☐

10. Mercurous chloride is:

   a. a deadly poison ☐
   b. Epsom salt ☐
   c. an anti-knock gasoline ☐
   d. calomel ☐

DENTISTRY,—

Where is Your Voice?

by W. A. MOLINE, D.M.D.

FRANKNESS! SPEED! Color! Drive! Daring! Dash! Rush! The streamline age is upon us!

Its advent is leaving many persons in a perplexed and even chaotic state of mind. Every phase of life is affected by a tremendous force called *change*. Business and the professions are caught in the maelstrom of social, economic, and political upheaval. Not only our physical existence but also our thinking and mental attitude have changed.

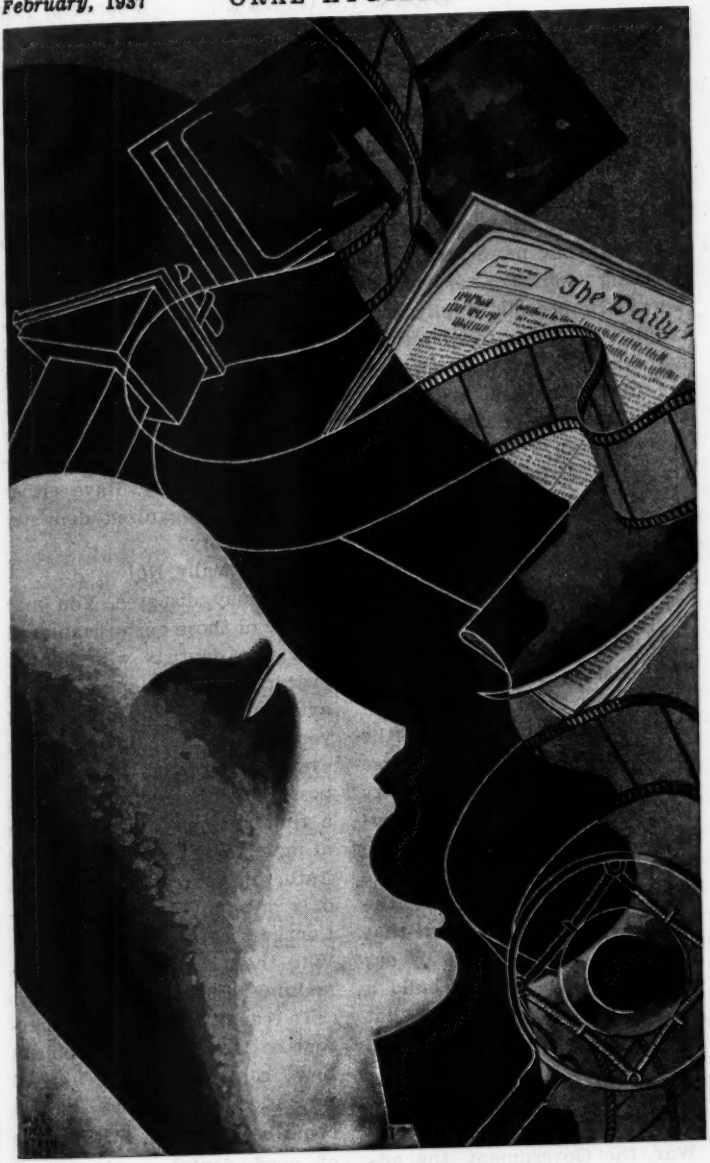
Dentistry is no exception in that it is not exempt from this tremendous change. True—antiquated ideas and standards exist even today, but as the years and even months pass these ideas will lose their strangle hold on a stubborn and change-resistant group.

Dentistry as a profession has risen from the status of the tinker to the position of mouth physician in the short span of a few generations. Progress has presented new problems. An ever increasing momentum carries us ahead, but we don't know where.

Two decades ago dentistry was struggling with technicalities. One decade ago the "brain-truster" economists high-pressured a then much heralded "new era" in applied economics —leaving their mark upon the profession. Today another more complex problem confronts us.

There appeared editorially in a recent issue of a dental trade journal the following statement: "It is a most hopeful sign that there is a rapidly increasing number of dentists who seek a vision far beyond the boundaries of their offices and who believe in the old adage 'where there is no vision the people perish.'" Such a statement should provoke reflection. It is the admission of lack of vision by some and an awakening in others. A mere awakening is not enough. It must be translated into action.

No doubt, because of lack of vision, a unique condition not existing in other professions pre-


The Daily

vails in dentistry. Although population is steadily increasing, with a consequent increased need for dentistry, the matriculation in our dental schools is steadily declining. Is not this condition a serious indictment of our profession, requiring investigation?

Why are not more young men choosing dentistry as a life work? To become a physician requires a longer time, yet the enrollment is steadily increasing in the medical schools. Is there a lack of prestige in dentistry? If so, who is to blame? Or can it be that the world does not yet place the proper valuation on dentistry's service to humanity?

Before we blunder ahead, let us remove our blindfold and take a look about. Let us analyze the existing relations between the dentist and the public.

Undoubtedly because it is the youngest of the professions, time has not yet accorded dentistry the respect granted older professions. Yet little has been done by the profession to encourage a respectful attitude on the part of the public. It is true that we cannot lift ourselves by our bootstraps, but we can build a ladder, a rung at a time, that will eventually bring us to a high place.

Instead of blaming fate, the gods, the depression, the World War, the Government, the advertising dentist, and other irrelevant conditions, let us as dentists and members of the American Dental Association recall our past actions, place them squarely before us, and with a critical eye, examine them to see what we really have done to better ourselves. Let no one attempt to belittle the profession nor to minimize the work carried on by organized dentistry through the American Dental Association.

There has been a great cry about telling the public our story of dentistry. Have either dentists or organized dentistry told the story?

Emphatically, No!

You may disagree. You may be one of those enthusiastic and energetic dentists who bubbles over in his office, hoping that an avid public will lap up some of your enthusiasm. But have you ever contemplated the utter impossibility of educating, one at a time in your office, a public of more than 125,000,000 people? Authentic sources establish that only one-fourth of the population ever enters a dental office. Who then is educating the remaining 90,000,000 people?

To reach the remaining three-fourths is one of the problems now confronting the dental profession. If that three-fourths could be interested in the value of good dental service, there

would not be enough dentists to do the work. Then, perhaps, the curve of matriculation in dental schools would rise. Young men would be interested in entering a field that would be both beneficial to humanity and lucrative to them.

What has been done to spread the story of oral hygiene and good dentistry among the people? Who has been responsible for the publicity that has already been meted out?

Publicity Bureau

Since the American Dental Association is the official representative of dentistry in the world of affairs, let us first examine its efforts. There is within the organization a Bureau of Public Relations. The very formation of such a bureau admits of the necessity for it. To criticize or belittle the efforts of the American Dental Association would not only embitter those in office but cast reflection on every member for lack of interest and activity. These thoughts are an effort to point out weakness in our present plans and workings and to analyze public estimation of our profession.

The Bureau of Public Relations has spent much time, effort, and money in accumulating an abundance of educational material for the use of the dentist or dental societies in educational work. The Bureau is to be commended for its work, not only for its range of subject material but also the quality. But to allow this excellent educational matter to lie on the shelf and collect dust until it becomes outmoded and stale is the height of extravagance and inconsistency. Why spend the money and time preparing this material if we don't develop a system of distribution to the public?

The conclusion must be drawn that the Bureau of Public Relations of the American Dental Association has performed the "bureau" part of its program very well, but has sadly neglected the "public relations" end of the project.

There have been local efforts at radio and newspaper publicity in various parts of the country. Virtually every dental society has at some time or another tried to do something similar. Some have spent considerable time and money; among others the efforts have been weak. Regardless of time, money, or perspiration expended, local effort will always prove ineffective, costly, undesirable from the public point of view, and, in many ways, objectionable.

Many societies have developed speakers to appear before the service clubs, parent-teacher groups, and to give health talks to school children, all basically

sound but woefully ineffective from the point of view of numbers reached.

To recognize the need for better education of the public on matters of oral health, one needs only keep eyes and ears alert in his office. Every day we have people come to our offices for treatment who show an amazing ignorance and misconception of oral hygiene and oral disease. To give these people a true picture will require time and patience. It will also require an extensive program designed to reach not only those people who come to our offices but also the countless millions who never darken the door of a dental office.

Public relations in dentistry have in the past been left entirely in the hands of the individual dentist. He has consciously moulded the opinion of the public immediately about him. The individual dentist has thus met the responsibility of building up public relations and public sentiment. Whether this has been favorable or unfavorable has depended entirely upon the individual—you! A collective building up of favorable public sentiment has been exceedingly conspicuous by its absence. This writer will venture that every interested dentist has had patients exclaim, "But, Doctor, why don't you fellows tell the public your story? I didn't know these things until you told me." Again the futility of educating one or a few people at a time is forcibly demonstrated.

Asks National Program

Until dentistry adopts a national program from which all local effort shall emanate, the whole public will never receive a uniform picture of dentistry! In the past the public has picked up a bit of information here and a story there and, having no sound basic understanding, is unable to distinguish between truths, half truths, or rank falsehoods concerning dental questions.

Let us examine other sources of publicity that dentistry is receiving. The dental story that is reaching the largest number of people is not coming from an impartial or unbiased source.

Now and then brief reference occasionally creeps into the pages of our current dental literature, such as found in this *Journal of the American Dental Association* item of February, 1935: "The toothpaste and mouth wash manufacturers have done far more to advertise dentistry and arouse the public to an interest in dental health than has the dental profession itself."

We do owe the dentifrice and mouthwash manufacturers a debt of thanks beyond words for

making the public as mouthwash conscious as they are. But we cannot ignore the fact that their educational efforts are secondary; to sell their product is of primary importance to them; we, necessarily, have a limited and partial picture presented.

Gradually, as the light of introspection is focused upon ourselves, we can scarcely refute an indictment branding this practice as a parasitical indulgence. We have "sponged" on the generosity of the dentifrice and dental manufacturers' publicity for so long that it has become "unethical" for the dental profession, as such, to foot its own publicity bill.

We have read and heard that the American Dental Association "frowns" on paid publicity. How long shall we continue to accept the gratuities of the commercial interests of the dental world?

The distinction between an amateur and a professional is that the professional gets paid for his services, and it follows that he pays his own expenses. Is it not high time the members of the dental profession with our national organization as our mouthpiece, emerge from our stiff-necked monomania and establish ourselves as mouth physicians anxious to tell the story of dentistry to a public hungry for true, unbiased, professional information?

We have a public to enlighten that has for a background only half-truths and fears. To reach and teach them will require a well developed and well organized nationwide program by the American Dental Association. Local efforts are a poor substitute. They are expensive and do not reach the masses. We cannot make a house to house call delivering lectures or sit at the telephone and inflict ourselves on busy people. We have to reach the public when they are in a more receptive mood and ready to listen and learn.

Our only hope for widespread public acceptance is by a national educational program, backed by organized dentistry.

210 *Rookery Building*
Spokane, Washington.

Editorial Comment

GIVE ME THE LIBERTY TO KNOW, TO UTTER, AND TO ARGUE FREELY ACCORDING TO MY CONSCIENCE ABOVE ALL LIBERTIES. *John Milton*

WHY NOT A PAN-AMERICAN DENTAL CONFERENCE?

IN DECEMBER of last year the Inter-American Peace Conference convened in Buenos Aires. Representatives of the twenty-one American republics that form the Pan-American Union attended this meeting. The President of the United States speaking before the Congress and the Supreme Court of Brazil sounded the keynote of the conference when he said: "Each one of us has learned the glories of independence. Let each one of us learn the glories of interdependence." With the Old World threatened by warfare on many fronts, with intrigues and aggression in the East, the western hemisphere alone—from Cape Horn to the Arctic Circle—enjoys peace and good will among the Americas.

President Roosevelt in his affirmation of faith in the western world declared that the democratic form of government must be preserved; that among the Americas there should be a wider distribution of culture, of education, and of free expression; that commerce and the exchange of art and science should be fostered among the nations; "that the faith of the western world will not be complete if we fail to affirm our faith in God."

This conference met under conditions of common trust and good will. There were no discussions of disarmament, because the Americans are not armed against each other. No plays of sly statecraft were made to divide the markets of the world; no mandates or protectorates or puppet states were hinted at, because none of the Americas is imperialistic.

On the official agenda of the conference were six items: organization for peace, neutrality, limitation of armaments, judicial problems, economic problems, and intellectual cooperation. We, as citi-

zens, are interested in all six; as dentists, we can do something about the establishment of cultural relationships and the exchange of art and science among the Americas.

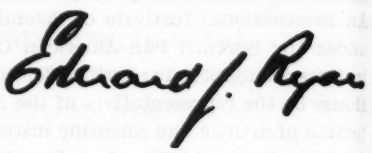
Proposals have already been made for the exchange of graduate students and professors among the twenty-one American republics. An International Institute of Scientific Research was provided for under the Seventh Pan-American Conference held in Montevideo in December, 1933. In April, 1935, a pact was signed at the White House by the representatives of the American republics for the protection of artistic and scientific institutions. The groundwork, therefore, has been laid. The dental profession in the United States has the historic opportunity to inaugurate, organize, and call the First Pan-American Dental Conference.

Except the American Dental Association, there is no dental organization in the United States important enough or representative enough to call such a conference. No local dental society or special society can speak for the dental profession of the United States. No promoters for any cause could organize such a meeting with dignity and true cultural purpose. The Atlantic City Meeting to be held in July presents the perfect geographic setting for such a Pan-American Dental Conference. The closeness of Atlantic City to the port of New York for those who would come by steamship and the location of Atlantic City for those who would come by air via Miami and the Pan-American Airways make the 1937 meeting of the American Dental Association the perfect opportunity to call the First Pan-American Dental Conference.

Winter cruises to the Caribbean and the Central and South American countries are becoming increasingly popular with persons from the United States. "Winter" cruises from South America to the United States should be popular with dentists from the South American countries. If so, they would fit the time of the Atlantic City Meeting exactly. June and July are the coolest months in both Brazil and the Argentine, for example.

Every sign points to an increase in the commerce between the United States and the other American republics. For the fiscal year ending June, 1936, the increase in this trade was 12.8 per cent over the preceding fiscal year. In 1931-33, 88.9 per cent of the goods from South America represented raw materials and food stuffs; in the same period 86.8 per cent of the goods exported from the United States were semi-manufactures or manufactures. This ratio of trade will probably continue with a constant increase in the total amount.

The dental profession has no direct part to perform in such commerce. We have, however, the opportunity to be among the first professional groups to advance cultural and scientific relationships and create good will among the Americas. The Atlantic City Meeting is our time!



COMMENDS DENTAL PUBLICATION

Under the title "Helps in Vocational Guidance," the December, 1936, issue of *The School Review*, an educational journal published by the University of Chicago, carried this interesting comment on DENTISTRY As A CAREER, a brochure reprinted from the *Bulletin of the Chicago Dental Society*, of which Stanley D. Tylman is the Editor:

"Among the publications helpful in guidance, particularly in its distributive aspect, at hand at this writing . . . is a brochure by L. E. Blauch, executive secretary of the American Association of Dental Schools' Survey Committee, which is reprinted from the *Bulletin of the Chicago Dental Society*. The brochure is called DENTISTRY As A CAREER and contains what will impress the critical reader as an exemplary treatment of the profession from the standpoint of the prospective entrant. Some captions will suggest the nature of the content: 'The Demand for Dentistry,' 'The Number of Dentists,' 'Women in Dentistry,' 'Earnings in Dentistry,' 'Qualities and Traits Needed in Dentists,' 'Advantages and Disadvantages of Dentistry as a Career,' and 'Cost of a Dental Education.' Copies of the reprint may be obtained for ten cents from the Chicago Dental Society, 30 North Michigan Avenue, Chicago."

RATE YOURSELF ON DENTAL FACTS

What is your score? Here are the correct answers for the statements made on page 184:

1. Gutta percha is similar to caoutchouc (c). (Gutta percha is the coagulated, milky juice of various trees of the genus *Palaquium*.)

2. Molybdenum is a metallic element (d). (A hard, silvery-white substance that occurs in nature chiefly in molybdenite.)

3. Novocaine has the chemical formula of $C_{13}H_{20}O_2N_2.HCl$ (a). (The technical name of novocaine is procaine hydrochloride or para-aminobenzoyl-diethylamino-ethanol hydrochloride.)

4. Odontexesis is the name of a dental operation (b). (Cleaning, scraping, and polishing of teeth.)

5. Epistaxis is the result of an injury to the nose (c). (Hemorrhage from the nose.)

6. William Harvey described the circulation of the blood (c). (English anatomist and physician, 1578-1657).

7. Marginal ridge is the name of part of a tooth (b). (The ridges on the outer margins of the occlusal surfaces of molars or bicuspid teeth.)

8. The gold inlay was first described by William Taggart of Illinois (c). (William H. Taggart (1855-1933) was a Chicago dentist who developed and, in 1907, made applicable to the casting of gold inlays the ancient principle of the "disappearing core.")

9. The theory of focal infection was advanced in 1910 by William Hunter (a). (William Hunter first announced this theory in an address at McGill University, Montreal, on "The Rôle of Sepsis and of Antisepsis in Medicine," October 3, 1910.)

10. Mercurous chloride is calomel (d). (Mercurous chloride, HgCl, is often confused with corrosive sublimate, a poison, mercuric chloride, $HgCl_2$.)

DEAR ORAL HYGIENE:

"I do not agree with anything you say, but I will fight to the death for your right to say it."—VOLTAIRE

Dentistry in the Future

In response to your request I am glad to comment on the question you propound "After the Diagnosis, What Treatment?"[1] in your December editorial. It is one that few can answer, because the opportunities offered to dentists in the public health field have been limited and few men in the practice of dentistry have had time outside of their technical work to study prevention and dentistry for children from a social, statistical and economic point of view.

May I suggest that a round table discussion be held to discuss and exchange views with interested and influential men in dentistry? At this session the public health point of view in relation to prevention and dentistry for children should be discussed and a possible program outlined. I have often stated my point of view in dental literature and a plan for such a service has been accepted in principle by the New York State Dental Society.

There is no doubt that the dental program of the future will be based on prevention and dentistry for children. *I am of the opinion that the emphasis in dental education has been on restoration and treatment of disease rather than upon prevention.* Dentistry is in a position quite different from medicine and systematic universal dental care for children will be a great boon to the public and the future practice of dentistry.

In addition to the division outlined in your editorial, the population may be divided into three groups as outlined in my paper entitled Universal Dental Care for Children:

1. All children.
2. Fortunate adults who have maintained a good set of teeth and need only reparative or conservative treatment.
3. Adults drastically in need of radical restorative treatment.

When you give consideration to the foregoing dental classifications, you must realize that if Group 1 were cared for regularly and systematically, Group 3 would eventually be eliminated, and Group 2 would be made dentally conscious, dentally self-sustaining, and anxious to carry out the lessons taught under provisions and advantages offered to Group 1. The book HEALTH DENTISTRY FOR THE COMMUNITY[2] by the Committee on Community Dental Service clearly shows the picture of dental needs. The subcommittee on which I served with

[1]Editorial, After the Diagnosis, What Treatment? ORAL HYGIENE 26A: 1608 (December) 1936.

Doctors J. O. McCall, Alfred Walker, Waldo Mork, Leuman M. Waugh, William J. Gies, the late Doctor John T. Hanks, and Miss P. Warner studied this problem for many years and when actively engaged in writing this report weighed carefully the data and statistical reports and came to the conclusions outlined in the book.

The next question is "How can a program be developed?" This I answered in the January, 1935,[3] issue of ORAL HYGIENE when I pointed out that it was not necessary to divide anew the boundaries of the United States, but that we could maintain our present sub-divisions of states, counties, and municipalities and through them administer projects to give dental service to children. This, of course, would necessitate the training of dentists for this particular work. In my opinion, the book PRINCIPLES AND PRACTICES OF PUBLIC HEALTH DENTISTRY by J. A. Salzmann, Alfred Walker, John Oppie McCall and Harry Strusser is an excellent formal text for the training of dental public health workers. If we had dentists properly trained in public health work and with a definite point of view and a common goal, great strides could be made toward the elimination or control of dental caries as "the most common defect among school children." *The individual local programs must be varied as to type according to the needs of the community and the ability to pay for dental service as well as in relation to the subsidies provided by the Social Security Act.*—HARRY STRUSSER, D.D.S., 175 Fifth Avenue, New York, New York.

[2]Committee on Community Dental Service: Health Dentistry for the Community, Chicago, University of Chicago Press, 1935.
[3]Strusser, Harry: Objects to Miller Plan, ORAL HYGIENE in Dear Oral Hygiene 25:49 (January) 1935.

Plan Radio Discussions

The Chicago Dental Society, encouraged by the results obtained through the broadcasts they have been sponsoring, known as the QUESTION BOX program and an INTERVIEW and CONVERSATIONAL program, is about to launch a unique feature on the air Saturdays, commencing January ninth at 2:00 p.m. over Station WJJD, which should be both educational and enlightening to the laity.

This series of broadcasts will be held in conjunction with the Chicago College of Dental Surgery of Loyola University, University of Illinois College of Dentistry, and the Northwestern University Dental School. It will be in the form of a Round Table Discussion, on dental subjects of general interest to the laity, given to them in an interesting manner.

The Chicago Dental Society broadcast will be represented by its officers and the groups representing the colleges will be selected from the faculty of the particular school broadcasting. There will be a Round Table broadcast every week, giving each group one broadcast a month. It is hoped that this program will be perpetuated if enough interest is shown in this type of educational discussion.—IRVING E. LABY, *Chairman, Radio Broadcasts Committee, Chicago Dental Society.*

Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply. Material of general interest will be published each month.

Dry Sockets

Q.—I am submitting to you the case of a woman, 43, who has suffered constantly from dry sockets. She has had nine extractions, and every one of them has terminated in a dry socket. I have also extracted teeth for this patient's son and daughter, and they, too, developed dry sockets in from three to five days.

Would you please give me the accepted theory as to the cause and nature of dry sockets? Is there such a thing as a tendency toward dry sockets being hereditary?

The following is a slight history of the patient:

She has a definite pansinusitis and on awakening in the morning her mouth is full of pus which she immediately rinses out. She has strong, good looking teeth and only three restorations in her mouth. She has a suppurative condition around the necks of three or four teeth which have been treated several times, but in about three or four weeks after each treatment, the suppuration recurs. She has a neuralgia of the neck, left leg, and shoulder, and her physician advised extraction of the remaining teeth, if there is any suspicion at all regarding focus of infection. It seems useless to give the patient further periodontal treatments. What do you suggest? If the teeth are to be extracted, should only one or two be taken out at a time? Also, what can I do to avoid dry sockets, or lessen the pain?—M. A. C., Virginia.

A.—Your letter raises a question which many men have tried to answer and some men think they have answered. Doctor Vastine of Pennsylvania believes that no one will ever have dry sockets who uses the preliminary treatment that he advises. Doctor Sinclair of Asheville, North Carolina, believes that many dry sockets can be avoided by breaking down enough of the buccal wall in case of maxillary teeth and the lingual wall in case of mandibular teeth to allow for good circulation of blood in the socket. Doctor Sinclair thinks also that he has overcome a tendency to dry sockets in many cases by filling the socket with calcium phosphate. A group of men at Columbia University in New York have had help in the filling in of sockets by the use of heterogeneous bone in the socket following extraction.

It is our practice to clear up all subgingival infection around the mouth before undertaking extractions, particularly if the

teeth are pulpless and have been for some time. For it is these old pulpless teeth which are most likely to have dry sockets following extraction. Depending upon the condition of the patient, the evidence of periapical infection and the severity of the extraction, we make our plans as to the number of teeth to be taken out at one time. If we have any doubt whatever we take out only one at the first sitting unless there are two adjoining teeth that need to be taken out, in which case we extract two, but if there are three or four together that should be taken out we do not feel at liberty to take out that many until we had found out about the reaction of the patient to extractions. When a dry socket develops, we immediately clean it out thoroughly and pack it with a sedative dressing. This will in most cases immediately stop the pain and induce granulation at the bottom of the socket. We ordinarily leave this pack in about a week, then remove it, and put in a fresh pack of a little smaller size. In this way we get the socket filled in without much pain.— GEORGE R. WARNER.

Extraction and Abscesses

Q.—Please give me your opinion as to whether I should extract teeth during the period of acute inflammation and acute abscesses.

It seems to me there is some confusion as to just what is the best practice and I should appreciate this information.—C. B. J., Louisiana.

A.—Your question is most pertinent but, as you say, there is a diversity of opinion as to the answer. Teeth have, in the past, been extracted when they ached, without regard to the type or stage of the inflammatory process. The very fact that in the majority of instances these extractions relieved the pain and were not complicated by any serious after results had led dentists to think that it is all right to extract a tooth whenever there is pain.

The tooth is, however, set in cancellous bone and it is not good surgical practice to operate when there is an acute inflammatory condition of either bone or soft tissue, but the results are likely to be particularly unfavorable in the case of bone. After Nature has set up a defensive wall around an inflamed area, the danger of infection from operative procedures is much lessened. We depend upon the history of the case as well as the appearance of bony tissues roentgenographically as to the time that it is safe to operate.—GEORGE R. WARNER.

Saliva Under Dentures

Q.—What can be done in a situation where the upper denture collects saliva under it to such an extent as to actually cause it to break contact with the underlying tissue. When the denture is washed and the mouth rinsed, the retention is as good as could be expected and stays that way for some time and then when pushed to place the saliva can be seen to emerge from under it. I might add that the post dam area is tight and that after a while the patient complains that the saliva, which is very ropy, strings out of the back of the denture causing gagging, which is relieved immediately upon washing

the denture and rinsing the mouth. The patient tells me that she consumes little sugar and starches.—S. D. R., Kentucky.

A.—In answer to your first question; if this were my patient, I think I should try to keep the saliva from collecting under the plate by altering the buccal contour. I would do a little experimenting by adding wax inside the buccal flanges and by trimming the contour toward the cheeks so as to direct the saliva away from the edge rather than over it.

This patient could most likely correct the ropy consistency of her saliva, if she would eat absolutely no starch or sugar for a few days and thereafter no more than she can take without having the saliva get too ropy again.—V. C. SMEDLEY.

Denture Construction

Q.—I have noticed that in making full upper dentures constructed according to modern prosthetic procedures, the first month or two they seem to be satisfactory in so far as retention is concerned. Then, following that time, a looseness begins which is even noticeable to the patient. This is not always the case, but appears to happen in about 35 per cent of my cases. I use nothing but modeling compound in taking the impression. If such looseness is the result of pressure, how can it be overcome or, what is your opinion?—H. F. K., Missouri.

A.—I think you must be displacing too much tissue, probably peripheral, with your modeling compound impressions. I would suggest that you do not try for so much suction in the beginning. I really think that the less suction dentures have the better, so long as they are sufficiently stable to stay in place during all of the necessary functions of eating, talking, smiling, and so on. Nature, of course, will not continue long to tolerate a tightness that interferes at all with normal circulation.—V. C. SMEDLEY.

Lip Biting

Q.—I have a patient who bites her lower lip frequently and it always occurs during her sleeping hours. She thinks that if the upper centrals and laterals were ground down, this would not happen. The danger of exposing the pulp is too great to try this. Is there some attachment made of velum rubber which could be used over her teeth?—L. S., New York.

A.—It is sometimes possible to overcome the difficulty of biting the lower lip by the simple expedient of grinding and polishing the labial incisal angle of the mandibular teeth. This is not only harmless but is usually beneficial from the point of view of traumatic occlusion. If this does not correct the condition, then it would be advisable to make a vulcanite splint covering the occlusal and incisal surfaces of all of the mandibular teeth and having the splint extend far enough over the teeth so that it will snap into place and will not readily loosen during the night. This will be large enough so there will be no danger of its being swallowed and, with the occlusion adjusted so that all of the maxillary teeth are in even occlusion against the splint, no harm can come either to the maxillary or mandibular teeth.—GEORGE R. WARNER.

Gingival Cavities

Q.—I have a patient, a man, 22, whose teeth are full of gingival cavities. The cavities begin and appear as if they were etched and eventually encircle the entire circumference of the tooth. These cavities indicate to me an acid condition of the system, but I had the patient take an antacid, which appeared to do no good. Please tell me how to treat this condition. I have placed restorations in several of these teeth, and in a short time decay appears around the margins of the restoration, although during the cavity preparation the cavities were extended to the sound tooth structure.—C. H. T., Texas.

A.—I would say that this extreme susceptibility to caries, as manifested by rapid decay of the cervical areas of the teeth, is one of the serious problems of our profession. While we do not know the whole story of dental caries, we are pretty well satisfied that nutrition is an important factor; therefore, in the case which you present, it would be advisable to have a complete physical examination for the patient which, of course, would include a report on blood chemistry so that you may know the calcium phosphorous balance in the blood.

In all probability you will find this balance is abnormal and that it will be necessary for this patient to increase his calcium-phosphorous intake and to activate the absorption of these minerals by the use of vitamin D. Cod liver and halibut liver oils are the best available sources of vitamin D in the winter, so your patient would have to resort to the use of fish oils. Then in addition to building up the resistance of the body, of course the oral hygiene should be carefully checked. Temporary inhibition of caries can be secured in the posterior part of the mouth by the use of ammoniated silver nitrate. I think if you will carry out this complete regime the condition will be improved within a year.—GEORGE R. WARNER.

Sensitive to Dentures

Q.—I have a patient wearing a partial upper vulcanite horse shoe type denture with two clasps. The gums become inflamed and sore when the denture is worn any length of time. I changed from red rubber to dark elastic, thinking there was some chemical action from the pigment in the red rubber. The soreness persists. What would you suggest as a remedy?—H. F. M., New York.

A.—You do not say so but I assume that this is a tissue borne partial with clasps without occlusal lugs, having the center of the palate cut out and with the vulcanite covering the rugae and extending up to the necks of the teeth on the lingual. If so, throw it away and make something definitely tooth supported with plenty of sturdy occlusal lugs. Cover the palate, if necessary, to connect and support the missing teeth but stay away as far as possible from the gingival margins of the teeth and, if possible, leave the rugae entirely uncovered. I believe that these tissue borne horse shoe type partial dentures are always injurious to the gums and teeth, though sometimes they are tolerated without the tissues be-

coming irritated and inflamed as in this case.—V. C. SMEDLEY.

Replacing Teeth

Q.—A boy, 10, was in an automobile accident and lost the six anterior mandibular teeth. The first bicuspids seem fully erupted and both deciduous second molars are in place and seem firm; the sixth year molars are also in place. Roentgenograms reveal no root fragments nor unerupted teeth in the area in question. How may I best replace these lost teeth?—C. E. H., Illinois.

A.—In my opinion, there is only one way to replace the lost teeth in the case presented in your letter and that is with a simple vulcanite denture. The margin of the denture should not impinge upon the gingival margins around the remaining teeth, and if possible the boy should be induced to wear it without any attachments to the remaining teeth. Such a denture will satisfy esthetics and maintain the present jaw relationship until the teeth are all erupted when, if desired, something more elaborate may be constructed.—GEORGE R. WARNER.

Photography and Inlays

Q.—I should like to know if there is any way in which gold inlays on anterior teeth can be covered to overcome the defect during photography.

I have restored an incisal edge of two upper centrals with white gold. Ordinarily it would not be noticed, but in taking a simple snap shot it would show up considerably, no doubt, due to the reflection of light by the gold.—J. H. H., District of Columbia.

A.—In reply to your letter, let me say that we have the same result you mentioned in photographing teeth. Not only do the metal restorations show clearly but also baked porcelain, silicate cement, and other materials show up. The camera is so faithful in its depiction of detail that it portrays things that the eye does not catch or notice.

I don't believe one can mask restorations so that the camera will not reveal them. If you cover the gold with varnish or take off the high polish, reflections from it will not affect the portrait unfavorably.—GEORGE R. WARNER.

Paresthesia After Extraction

Q.—A few days ago a woman came into my office to consult me about an extraction another dentist had performed for her about ten weeks before.

Her dentist had done a simple third molar extraction, lower right side, using conductive anesthesia. She said the tooth came out easily without any trouble whatsoever. The right side of the jaw has been numb since the extraction and began to be painful about a month ago. Within the last week it has become intensely painful.

Upon examination I found the teeth slightly loose and sensitive to percussion, being worse centrally and becoming less loose and sensitive as I proceeded posteriorly.

They responded to the pulp tester and a set of roentgenograms showed up negative results.

I realize that where there is a nerve injury from a mandibular injection there is total or partial anesthesia for some time, but I have never heard of a case in which the teeth became loose and there was pain.

What do you think caused the condition in this case, and what method of treatment do you suggest?—O. H. D., Virginia.

A.—It is not uncommon to have paresthesia or anesthesia following the removal of a mandibular third molar, even though it is a simple extraction. This condition is accounted for by the fact that not infrequently the apex of the third molar root lies so close to the inferior dental canal; and the connection between the pulp and the tooth and the contents of the inferior dental canal is so strong that when the tooth is extracted there is heavy traction on the contents of the canal and there is probably a rupture of blood vessels and a tearing of nerve tissue.

As in your case, this is sometimes followed by hyperesthesia, although hyperesthesia is rare. The symptoms of loose and sore teeth point to more serious trouble. I would suspect an osteomyelitis. This disease should be interpretable in the intra-oral films. However, if you have not seen roentgenograms of a number of such cases you might overlook this disease. If you will make two or three new exposures of this region and send them to me together with the ones that you made before you wrote the letter, I will attempt to interpret the new ones for you. In the meantime, hot moist applications over the mandible would be in order. Magnesium sulphate added to the water improves the action of these hot moist packs. —GEORGE R. WARNER.

Effect of Hydrochloric Acid

Q.—I have a patient, a woman, who up to three years ago had an excellent set of teeth, with only a few small restorations. Some months ago, probably a year or two, she had an infection of her leg and was treated for some time by her physician with dilute hydrochloric acid given internally. The infection of her leg was controlled, but I made an examination of her teeth a few months back and I find that her teeth seem to be developing dark spots in the enamel; in fact, some of the places are gradually beginning to decay after these spots remain for a while.

I will ask you to give your opinion in this case and state whether you think that the acid has anything to do with this condition and, if it has, what would be your treatment?

This patient is taking no medicine at the present time.—C. E. W., Georgia.

A.—Hydrochloric acid taken by the mouth without proper protection of the teeth will inevitably cause a dissolution of the enamel of the teeth. This can be avoided by substituting acidulin pulvules for the ordinary dilute hydrochloric acid. Acidulin is glutamic acid hydrochloride. Each pulvule contains the equivalent of ten drops of dilute hydrochloric acid.

If the patient wishes to continue taking dilute hydrochloric acid, she should take it through a medicine tube and should have a thin vulcanite or wax plate made to cover the lingual surfaces of the ten anterior maxillary teeth, then as she sucks the hydrochloric acid through the medicine tube the teeth are protected. After she has taken

the hydrochloric acid the mouth should be thoroughly washed until any acid on the tongue is neutralized.—GEROGE R. WARNER.

Metallic Taste

Q.—Will you please advise me in regard to the cause and treatment of the following case?

A railroad engineer, 44, complains of a decidedly strong metallic taste in his mouth which has persisted for the past three and one-half months.

His gums and oral tissues are in a healthy condition, and his teeth are well cared for.

The restorations in his teeth are of gold, amalgam, and silicate (gold predominating) and there is a small bridge on the anterior lower jaw. There is one place only where a gold and amalgam restoration are in contact.

About three weeks ago the patient had a thorough physical examination and he was found to be all right in every respect. At that time his physician prescribed Seiler's Tablets, dissolved in warm water, to be used as a mouth wash three or four times daily. For about two weeks the metallic taste was virtually absent. Now it is as bad as previously and causes him so much annoyance that he wishes, at times, his teeth were out.

The patient is not a drinker and smokes moderately, drinks one cup of coffee at breakfast, and drinks milk with all other meals.

If the different restoration materials in his mouth have any bearing on the condition why has this metallic taste been apparent to him for only the past 3 or 4 months, when the restorations have been in his mouth for years? There is no odor or bad breath. The patient eats meat moderately, and the metallic taste seems to be more pronounced after meals.—S. B., Utah.

A.—The case presented in your letter is one of the most difficult with which we have to deal. The fact that your patient has had dissimilar metals in his mouth over a period of years and then suddenly this metallic taste develops does not make it impossible that the dissimilar metals are somewhat at fault, because there might have been some change in the saliva in the meantime that gives it a greater electrolytic action. Of course I don't know how thorough a physical examination the man had, but it should have included a Wasserman test, and the anemias should be ruled out because early indications of anemia are peculiar tastes in the mouth.

The psychic action and effect of these cases has to be considered also. For instance people sometimes get to thinking about themselves too much and decide that there is a salty taste in their mouth. Then if they become busy or diverted, they forget all about the salty taste. If your patient had his teeth taken out, it might not make the slightest difference about the taste so he had better not do anything impulsive. I can't think of anything further that would have a bearing on this case and I regret that I can't give you more definite information.—GEORGE R. WARNER.

Looking into
DENTAL PATIENTS' *Minds*

Work on this patient study covered more than a year, because of the great amount of data it was necessary for the editorial staff to digest, analyze, and chart.

"WHAT DO YOU think causes toothaches?" When twelve hundred typical dental patients were asked that question, it was necessary to classify under nineteen different heads 1,644 different reasons they gave. Each of the nineteen classifications included a variety of reasons. A surprising percentage answered the question intelligently; others advanced more or less fantastic conceptions, such as, "Excitement"; "Indigestion from eating too much sweets"; "Film"; "Decay in tooth caused by too large a filling"; and "Sugar diet deficiencies."

When these same persons were asked, "Of what use is an x-ray of the teeth?" a high percentage gave sensible answers. Among the smaller group, the replies included such statements as, "Not much, probably helps the dentist in some way"; "When color photography is perfected we may know more"; and "Merely to satisfy the patient." The twelve hundred patients gave 1,517 replies to this question.

Last month, as announced in January ORAL HYGIENE, the first article in the series, "What Twelve Hundred Patients Know About Dentistry," was published in *The Dental Digest*. The series is based on an ORAL HYGIENE PUBLICATION study in which thirty-seven practicing dentists cooperated. The response, representing the opinions of twelve hundred dental patients, included patients of various educational and income levels, widely distributed geographically—from Holyoke, Massachusetts, to San Francisco; from Fargo, North Dakota, to Wisner, Louisiana. Patients in big cities, small cities, towns, and villages were embraced by the study.

The cooperating dentists, whose names are listed in the January *Dental Digest* article, gave a questionnaire, furnished

by the magazine, to each of the first fifty adult patients entering their offices. Patients were required to fill them out in the dentist's office, not being permitted to take the questionnaires home. They were not prompted by the dentist, and patients themselves sealed their answered questionnaires in return envelopes addressed to the Editorial Director of ORAL HYGIENE PUBLICATIONS.

Work on the project covered more than a year, because of the great volume of data which it was necessary for the editorial staff to digest, analyze, and chart, before preparing the articles. Twelve questions were asked, as follows:

1. What do you think causes a toothache?

2. Of what use is an x-ray of the teeth?

3. What do you think causes tooth decay?

4. Would you like an injection of a local anesthetic while having a tooth drilled?

5. What is your understanding about pyorrhea; in other words, what do you think it is?

6. How long do you expect dental work that has been done (fillings, bridges, for instance) to last?

7. What relation do the teeth have to general health?

8. Do you think of an extraction of a tooth in the same way as you do of an operation?

9. What do you expect a toothpaste or toothpowder to do for you?

10. Do you think it is necessary to fill cavities in the "first" ("baby" or "temporary") teeth?

11. Are crooked teeth and poorly developed jaws in children something that they "outgrow?" What are your opinions?

12. What do you think brings about the need for artificial teeth? Do you think it is "just one of those things" that comes with advanced age?

In February *Dental Digest* the series continues, taking up the questions, "What do you think causes tooth decay?"; "Would you like an injection of local anesthetic while having a tooth drilled?"; "What is your understanding about pyorrhea; in other words, what do you think it is?"; "How long do you expect dental work that has been done (fillings, bridges for instance) to last?"; "What relation do the teeth have to general health?"; and "Do you think of the extraction of a tooth in the same way as you do of an operation?"

The series will continue in the March and April issues of *The Dental Digest*.

DENTAL COMPASS

Traveling Clinic in Louisiana

An interesting advance in public health service was recently reported by the Shreveport and Caddo Parishes of Louisiana—the purchase and equipment of a dental trailer for the purpose of examining the teeth of school children free and performing necessary extractions, placing restorations, and giving other dental attention without cost for the children of indigent parents.

The Public Health Department, which is financed by city, parish, and state funds, is entirely responsible for the financing and purchase of this new trailer. The unit is completely equipped as a modern dental office for children, and the floor space is large enough to permit eight or ten adults to stand in the office together at the same time.

Doctor J. G. Yearwood, Jr., has been employed as a full-time dentist to take charge of the dental trailer. He will visit every country school regularly and will perform dental services for certain of the younger students free of charge. These students will be selected through the cooperation of the Parent-Teacher association, school teachers and principals, the dental societies, and various relief organizations.

Education, not treatment, however, is the principal object of the unit. When Doctor Yearwood visits the various schools, he will lecture to the children on dental health, distribute literature on the care of the teeth, and will aid in such dental-education work as tooth-brush drills.

This project for bringing dental service and education directly to school children is being watched with interest by public health departments and dentists throughout the country.

Dental Supervisor Named

Doctor F. A. Bull, Milwaukee, has been appointed as Supervisor of Dental Education, a new position created, much to the satisfaction of the Wisconsin State Dental Society, by the State Department of Health.

Following a civil service examination in which more than forty applicants participated, Doctor Bull received the appointment and assumed his new duties December 1, 1936.

By training and experience he is well fitted for health service. Previous to his graduation from Marquette Dental School in 1923, Doctor Bull had attended the University of Paris under United States Army regulations subsequent to the World War. For a number of years Doctor Bull has been engaged in private practice in Milwaukee. He has also been doing extensive research on amalgam, a subject on which he has presented scientific papers before meetings of the American Dental Association as well as at various state and county dental society meetings.

The boy had been spending the afternoon getting into all kinds of trouble, until finally a neighbor collared him and asked him why he did not go straight home after school, with the other children.

Boy (in surly tone): "I'm locked out."

Neighbor: "Why locked out? And where's your mother?"

Boy: "Down at the Mothers' Club Meeting, telling them how to raise children."

o

A pretty young nurse was selling poppies. A salesman told her he would give her a five dollar bill for a poppy provided she would promise to nurse him if he ever went to her hospital. She agreed.

Salesman: "By the way, where is your hospital?"

Nurse: "I am at Queen Charlotte's maternity hospital."

o

Visitor: "Your uncle seems a little hard of hearing."

Jasper: "Hard of hearing! I should say so! Why, once he conducted family prayer kneeling on the cat!"

Friend: "Did I understand you to say you bought your automobile for a song?"

Man: "Well, not exactly. I bought it for a flock of notes."

o

Doctor: "Yes, it is some chronic evil which has deprived you of health and happiness."

Patient: "Sh-s--sh! Speak softly. She's in the next room."

o

There was great excitement aboard the giant ocean liner: "Man overboard!" was the cry.

"Gentleman overboard, if you please," said Mrs. De Snobbe. "That's my husband."

o

A bricklayer working on the top of a very high building accidentally knocked a brick off the scaffolding with his foot and it unfortunately landed on the head of a negro who was passing.

Negro (shouting): "Be careful, up there, Big Boy, you made me bite mah tongue!"

o

BEHOLD THE FISHERMAN

He ariseth early and maketh great preparations and e'er the sun is fully risen he goeth forth full of hope and great expectations. And when the day is far spent he returneth smelling of strong drink and the truth is not in him.

o

Professor: "What do you know of Latin syntax."

Freshman: "Did they have to pay for their fun, too?"